



Pat Quinn, Governor

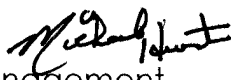
Illinois Department of Human Services

Michelle R.B. Saddler, Secretary

319 East Madison Street • Springfield, Illinois 62701

DATE: April 29, 2010

TO: Executive Directors of CILA, Developmental Training, and Child Group Home Programs

FROM: Michael Hurt, Chief 
Bureau of Quality Management

SUBJECT: Quality Assurance, Injury and Medication Error Reporting

Various administrative rules, as well as the Division of Developmental Disabilities Community Services Agreement (CSA) Attachment A, require written quality assurance plans and ongoing activities by providers to review and evaluate services (including injuries and medication errors). That review must include the collection of data and review of circumstances leading to any adverse event as well as the identification and implementation of improvements to prevent such injury or other adverse event in the future. See Rules 115 {115.320, g}); 116 {116.100, b) and c}); {116.370 c}); 119 {119.260 g) and h}) and the CSA Attachment A (section VIII. M. 4.) for more details.

For the past several years, residential providers with settings of 16 persons or fewer (CILAs and, more recently, Child Group Homes) have been further required to submit evidence of their review of injuries and medication errors on a quarterly basis and Developmental Training (DT) programs have been required to submit evidence of their review of injuries on a semi-annual basis. The Division had communicated these additional reporting expectations through memoranda, typically from the former Bureau of Quality Assurance and System Improvement. That oversight was not intended to duplicate agencies' internal review processes, but rather confirm the presence and effectiveness of said systems as they relate to the health and safety of persons receiving services.

The purpose of this memorandum is to advise you that the Division of Developmental Disabilities has examined agency reporting practices and has determined that submission of your quarterly/semi-annual medication error and/or injury reports to the Division's Bureau of Quality Management (BQM) is no longer required. At least quarterly, **providers must continue to conduct and document their own internal review of all adverse events** (including but not limited to injuries, medication errors and deaths). In an effort to reduce demands on provider agencies and improve efficiencies within BQM, verification of provider agencies' systemic internal reviews, required at least quarterly, will occur in conjunction with periodic quality assurance and/or medication administration review visits by BQM.

Medication errors for which there is an adverse outcome to the person receiving services must continue to be reported, via fax, within 7 calendar days of discovery to the Bureau of Quality Management. A copy of a suggested medication error reporting form is enclosed. Use of this specific form is not required. Providers may use their own agency-developed form for purposes of documenting all medication errors, provided the agency-developed form provides the same information.

These reporting requirement changes are specific only to the Division of Developmental Disabilities and do not impact any requirements to report events to the DHS Office of the Inspector General.

In summary, CILA, DT and Child Group Home providers should:

- Conduct analysis of all adverse events, including medication errors, injuries, and deaths, at least quarterly.
- Maintain documentation of adverse event review and analysis at the agency but do not submit it to the Division of Developmental Disabilities, Bureau of Quality Management.
- Fax adverse outcome medication errors to the Bureau of Quality Management (217) 782-9444 within 7 calendar days of discovery.
- Continue to report events to the Office of the Inspector General, as required by Rule 50.

Please feel free to contact the Bureau of Quality Management at (217) 782-9438 if you need further clarification.

Enclosure